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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WASHINGTON
AT YAKIMA

STATE OF WASHINGTON,

Plaintiff,

v.

ALEX M. AZAR II, et al.,

Defendants.

NATIONAL FAMILY PLANNING & REPRODUCTIVE HEALTH ASSOCIATION, et al.,

Plaintiffs,

v.

ALEX M. AZAR II, et al.,

Defendants.

NO. 1:19-cv-03040-SAB

STATE OF WASHINGTON'S MOTION FOR PRELIMINARY INJUNCTION

NOTED FOR: April 25, 2019
With Oral Argument at 10:00 a.m.

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I. INTRODUCTION AND RELIEF REQUESTED

On March 4, 2019, Defendants (collectively, "HHS") issued a Final Rule that will destroy almost 90% of Washington's statewide family planning network. Contrary to Congress's directive that HHS use grant funds under Title X of the Public Health Service Act to establish projects that make "comprehensive voluntary family planning services readily available to all persons desiring such services," under the Final Rule the number of Washington counties *without* a Title X provider will jump from five to 21. This will leave low-income patients in more than half of Washington's counties without ready access to Title X family planning services.

The State of Washington moves for a preliminary injunction prohibiting HHS from implementing the Final Rule, which is scheduled to go into effect on May 3, 2019. The Final Rule makes drastic and unlawful changes to five decades of regulations implementing Title X, the nation's family planning program for low-income individuals. The Final Rule violates *three* controlling statutes, and is arbitrary and capricious for a host of reasons. It must be enjoined to prevent devastating harm to the State of Washington's family planning network, and the tens of thousands of patients who depend on it.

First, the Final Rule violates Congress's mandate that all pregnancy counseling in a Title X program "shall be nondirective" (the "Nondirective Mandate"), which is included in the appropriations act that funds HHS through

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September 2019 (and every annual appropriations act since 1996). Contrary to the Nondirective Mandate, the Final Rule requires that *all* pregnant patients receive directive referrals for prenatal care, prohibits referrals for abortion (including at the patient's request or when medically indicated), and permits clinic staff at their discretion to give only directive counseling that pushes patients toward carrying the pregnancy to term.

Second, the Final Rule violates section 1554 of the Patient Protection and Affordable Care Act (ACA) in a number of different respects. It mandates strict and costly separation of abortion-related speech and services from Title X-funded services—not just financially, but physically—which, along with the coercive pregnancy counseling requirements and other new provisions, will force out the Title X clinics comprising 89% of Washington's statewide network, leaving low-income patients without access to services. The few clinics able and willing to stay in the program will have to provide substandard care that omits accurate medical information needed for informed decisionmaking and steers patients toward the government's preferred treatment option. Both outcomes violate section 1554, which prohibits the Secretary from promulgating "any" regulation that delays or creates barriers to medical care, interferes with patient–provider communications, or violates principles of informed consent and medical ethics.

Third, the Final Rule violates Title X, as its effect fundamentally betrays the statute's central purpose: equalizing access to modern, high-quality, effective

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contraception and other family planning services, regardless of a person's economic condition. Forcing highly qualified and demonstrably successful providers out of Washington's Title X program (based on care they provide *independent* of the program) will inevitably reduce access to care, worsen health outcomes, and hurt the very people the statute was intended to help. In addition, the coercive counseling requirements violate the statutory command that receipt of Title X services and information be strictly "voluntary." Furthermore, the Final Rule exceeds HHS's authority and is arbitrary and capricious. In its single-minded pursuit of policy goals unrelated to Title X, HHS ignored extensive evidence in the record and failed to meaningfully respond to a host of public comments, including unanimous opposition from leading medical associations.

The Final Rule is an executive overreach aimed at implementing policy objectives disconnected from Title X. An agency cannot enact new policies through a rulemaking that ignores or unrecognizably twists the meaning of controlling statutes, or that brushes aside extensive evidence of the harm it will cause. Agencies are strictly bound by laws duly enacted by Congress—and here, Congress has spoken clearly, consistently, and repeatedly.[1]

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[1] In addition to these consolidated cases, five other cases challenging the Final Rule have been filed: Nos. 19-cv-217, 19-cv-318 (D. Or.); Nos. 19-cv-1184, 19-cv-1195 (N.D. Cal.); No. 19-cv-100 (D. Me.).

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II. STATUTORY AND FACTUAL BACKGROUND

A. Overview of Title X and Washington's Program

Title X[2] is the nation's safety-net family planning program for low-income individuals. Through grants to states like Washington and other qualifying entities, Title X funds "projects" or "programs" nationwide that offer a "broad range of acceptable and effective family planning methods and services[.]"[3] Title X programs offer patients a wide selection of contraceptive methods and services; testing for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV); cancer screenings; pregnancy testing and counseling; and referrals for out-of-program care.[4] Per section 1007 of the statute, the acceptance of all Title X services and information must be strictly "voluntary."[5] Per section 1008, Title X funds may not be used for "abortion as a method of family planning."[6]

Title X's primary purpose is to equalize access to modern, effective

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[2] 42 U.S.C. § 300 *et seq.*

[3] *Id.* § 300(a).

[4] *Id.*; 42 C.F.R. § 59.5(a).

[5] 42 U.S.C. § 300a-5.

[6] *Id.* § 300a-6. Congress has made clear that section 1008 is consistent with requiring that Title X pregnancy counseling be nondirective. *See infra* at 6–7.

contraception to help women avoid unplanned and unwanted pregnancies.[7] The statute was passed with strong bipartisan support in 1970 in response to a growing body of evidence that, due to low-income women's lack of access to effective contraception, they had less control over their reproduction than more affluent women, creating adverse health and economic outcomes.[8] First among Title X's stated purposes is "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services"; a related goal was to "improve the effectiveness of family planning service programs" in helping people determine freely the number and spacing of their children.[9]

The Washington State Department of Health (DOH) is the sole grantee[10] of Title X funds in Washington and runs a statewide program pursuant to state law, overseeing a network of 16 subrecipient organizations operating 85 clinic

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[7] *See id.* § 300; ECF No. 1 (Compl.) ¶¶ 22–26.

[8] *Id.* ¶¶ 19–21.

[9] Pub. L. No. 91-572, § 2, 84 Stat. 1504 (1970).

[10] Washington has standing to sue as a grantee, *see, Nat'l Family Planning & Reprod. Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 239 (D.C. Cir. 1992), and to vindicate its sovereign, quasi-sovereign, and proprietary interests, *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 600–07 (1982).

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sites.[11] Approximately one third of the program is funded through Title X grants, while the remainder is State-funded.[12] This integrated, jointly funded program served over 91,000 low-income patients in 2017 (57% of whom were at or below the federal poverty level), saving over $113 million in health care costs and helping women avoid over 18,000 unintended pregnancies that year alone.[13]

B. Other Controlling Statutes

HHS is authorized to issue regulations implementing Title X, subject to statutory limitations on its rulemaking authority found in Title X and elsewhere.[14] One such limitation is the Nondirective Mandate included in decades' worth of annual appropriations acts.[15] The Department of Health and Human Services Appropriations Act, 2019, which funds HHS through September 2019, provides that all Title X pregnancy counseling "shall be nondirective[.]"[16]

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[11] Harris Decl. ¶ 14; WA cmt. at 4; RCW 43.70.040(5). For the Court's convenience, citations to public comments in the rulemaking record are both hyperlinked and attached to the Beneski Declaration as Exhibit 1.

[12] Harris Decl. ¶ 24.

[13] Harris Decl. ¶¶ 26, 33; WA cmt. at 5.

[14] *See* 42 U.S.C. §§ 300–300a-4.

[15] Compl. ¶ 49 n.15 (citing appropriations acts 1996–2018).

[16] Pub. L. No. 115-245.

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Another limitation on HHS's authority is section 1554 of the ACA, which provides that the Secretary "shall not promulgate any regulation" that—

> (1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;
> (2) impedes timely access to health care services;
> (3) interferes with communications regarding a full range of treatment options between the patient and the provider;
> (4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions; [or]
> (5) violates the principles of informed consent and the ethical standards of health care professionals . . . .[17]

C. Five Decades of Title X Regulations

Since the 1970s, Title X regulations and guidance have governed grantees' provision of a broad range of effective, medically approved contraception and other family planning services, including nondirective pregnancy counseling and referrals for out-of-program care, while ensuring compliance with section 1008.[18] The sole exception was an anomalous 1988 "gag rule" that was swiftly enjoined and never implemented in fact: it prohibited nondirective pregnancy counseling, including referral for abortion, and for the first time required physical separation of abortion care.[19] The gag rule was upheld as a permissible construction of

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[17] 42 U.S.C. § 18114.

[18] *See* Compl. ¶¶ 29–47.

[19] *Id.* ¶¶ 33–36; 53 Fed. Reg. 2922 (former 42 C.F.R. §§ 59.8, 59.9).

Title X in the pre-Nondirective Mandate case of *Rust v. Sullivan*, 500 U.S. 173 (1991), but was rescinded in early 1993 amidst a public outcry and continued litigation.[20] Congress has since shut the door on regulations like the gag rule.

The Current Regulations reinstated the pre-*Rust* status quo.[21] In 1996, Congress began including the Nondirective Mandate in its annual appropriations acts,[22] prompting the HHS Secretary to observe in 2000 that "Congress has repeatedly indicated that it considers this requirement to be an important one[.]"[23] The Secretary further noted that "the requirement for nondirective options counseling has existed in the Title X program for many years, and, with the exception of the period 1988–1992, it has always been considered to be a necessary and basic health service of Title X projects"; moreover, nondirective counseling is "consistent with the prevailing medical standards" recommended by national medical groups.[24] Accordingly, the Current Regulations require Title X projects to offer "neutral, factual information" about all pregnancy options—"prenatal care and delivery"; "infant care, foster care, and adoption";

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[20] *Id.* ¶¶ 37–39.

[21] 65 Fed. Reg. 41270 (Jul. 3, 2000), 42 C.F.R. Part 59; Compl. ¶¶ 40–47.

[22] Compl. ¶ 49 n.15.

[23] 65 Fed. Reg. 41273.

[24] *Id.*

and "termination of pregnancy"—and referral upon request, unless the patient does not wish to receive such information about a particular option.[25]

In addition, HHS's Program Requirements require Title X projects to provide nondirective pregnancy counseling, and incorporate the "QFP" and its updates.[26] The QFP reflects evidence-based best practices for "Providing Quality Family Planning Services" in the United States, and requires that "[o]ptions counseling should be provided" to pregnant patients as recommended by the American College of Obstetricians and Gynecologists (ACOG) and others.[27]

D. The Final Rule

The Final Rule[28] reverses longstanding policies reflected in the Current Regulations and Program Requirements. It will disrupt Title X programs like Washington's that are currently functioning smoothly. If the Final Rule goes into

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[25] 42 C.F.R. § 59.5.

[26] Beneski Decl. Ex. 2 (Program Requirements), 3 (QFP), 4 (QFP update).

[27] QFP at 14; Coleman Decl. ¶¶ 63–64; Kost Decl. ¶¶ 22–25; AAP & ACOG, *Guidelines for Perinatal Care* at 127 (7th ed. 2016) (patient with unwanted pregnancy should be "fully informed in a balanced manner about all options, including raising the child herself, placing the child for adoption, and abortion"); ACOG cmt. at 6; Compl. ¶ 46.

[28] 84 Fed. Reg. 7714, ECF No. 1-4 (Compl. Ex. A).

effect, it will impede patients' access to complete and accurate information and medical care, whether funded by Title X or otherwise—violating multiple controlling statutes, irrationally overturning five decades of precedent, and exceeding the scope of the Secretary's rulemaking authority.

First, the Final Rule imposes coercive and misleading pregnancy counseling requirements that brazenly violate the Nondirective Mandate and other post-*Rust* laws. It broadly prohibits referrals for abortion, striking requirements that patients be referred for out-of-program care upon request and for "medically indicated" care.[29] It requires that all pregnant patients receive directive referrals for prenatal care absent an "emergency," regardless of the patient's wishes (or the provider's medical judgment).[30] At the same time, the Final Rule purports to permit "nondirective" pregnancy counseling (if provided by physicians or "advanced practice providers"),[31] but alternatively allows any clinic staff to give only biased, one-sided information about carrying to term.[32]

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[29] Final Rule §§ 59.5(a)(5), 59.5(b)(1), 59.14(a); *compare* current 42 C.F.R. §§ 59.5(a)(5), 59.5(b)(1); Compl. ¶¶ 71, 78.

[30] Final Rule § 59.14(b); Compl. ¶ 72.

[31] Final Rule §§ 59.14(b)(1)(i), 59.2; Compl. ¶¶ 74–75.

[32] 84 Fed. Reg. 7714 (revised 42 C.F.R. § 59.14(b)); Compl. ¶ 72.

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Second, the Final Rule imposes onerous and unworkable physical separation requirements in addition to the statute's financial separation requirement, without sufficient justification. If a grantee or subgrantee provides abortion care or referral, or engages in expressive or associational activities such as supporting access to safe and legal abortion, those activities must be physically separated from Title X services.[33] "Factors relevant to" adequate separation include the existence of separate treatment, consultation, examination and waiting rooms; separate office entrances and exits; separate phone numbers and email addresses; separate websites; separate educational services; separate personnel; separate workstations; separate electronic health records; and the presence or absence of signage "referencing" abortion.[34] HHS emphasized that employing separate Title X and non-Title X staff is insufficient separation, that co-locating Title X activities and abortion-related activities within a single space is impermissible, and that separate electronic health records systems are mandatory.[35] Many clinics cannot bear the financial costs—which commenters anticipate will be over twenty times HHS's unsupported estimate of $30,000 per

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[33] Final Rule § 59.15; *see id.* §§ 59.13, .14, .16; Compl. ¶ 90.

[34] Final Rule § 59.15; Compl. ¶ 91.

[35] Supp. Info., 84 Fed. Reg. at 7764–67, 7769.

clinic—or cannot meet the one-year deadline.[36] Those that try to scramble to comply will have to provide unethical and substandard care, divert limited resources away from caring for patients, and reduce their hours or close their doors during construction, further reducing access to care for no good reason.[37]

Third, the Final Rule makes a number of other changes that will unlawfully and arbitrarily reduce access to care, impose needless costs, and undermine the purpose of Title X: removing the requirement that Title X services be "medically approved";[38] requiring that Title X clinics offer or be in close proximity to "comprehensive primary health care services" (which are outside Title X's scope);[39] jeopardizing the right to apply for a grant by vesting HHS with broad discretion to arbitrarily determine eligibility;[40] and limiting the uses of Title X funds (even uses expressly contemplated by the statute).[41]

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[36] *See* PPFA cmt. at 32, 73–74; NFPRHA cmt. at 37; Eastlund Decl. ¶¶ 14-20 (estimating compliance costs of $6.5 million in first year); 84 Fed. Reg. 7782.

[37] Compl. ¶¶ 102–108; *see infra* at 15–16, 23–24, 34–35.

[38] *Compare* Final Rule § 59.5(a)(1) *with* current 42 C.F.R. § 59.5(a)(1); Compl. ¶¶ 109–113.

[39] Final Rule § 59.5(a)(12); Compl. ¶¶ 114–120.

[40] Final Rule § 59.7(b); Compl. ¶¶ 126–132; NFPRHA cmt. at 31.

[41] Final Rule § 59.18(a); Compl. ¶¶ 133–134.

E. The Final Rule's Impact on Washington

As Washington explained in its public comments, the unlawful Final Rule will disqualify critical Title X providers and dismantle the State's successful family planning program.[42] This will leave many patients with diminished or no access to needed care, exacerbating the negative health and economic outcomes Title X was meant to address.[43] The consequences for the State and its residents cannot be fully remedied if the Final Rule goes into effect.

Five current subrecipients of Title X grant funds operating 35 clinics in Washington have informed DOH that they cannot meet the Final Rule's new requirements.[44] In 2017, these clinics served 89% of the Title X patients in Washington.[45] Their departure will leave 21 of Washington's 39 counties without *any* Title X provider: 11 in Eastern Washington and 10 in Western Washington

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[42] WA cmt. at 4–5, 24–25.

[43] *Id.* at 26.

[44] Harris Decl. ¶ 60. Other subrecipients, clinics, and individual providers are likely to leave as well, due to the Final Rule's costly required separation and imposition of unethical and contraindicated medical care. *Id*. ¶ 64; *cf*. Eastlund Decl. ¶ 8; Kruse Decl. ¶ 40; Maisen Decl. ¶ 42; Adams Decl. ¶¶ 34–40, 43–51.

[45] Harris Decl. ¶ 60.

(including six of the 10 most populous counties in the State).[46] Patients in those counties will have to travel hundreds of miles to the nearest Title X clinic, overburdening clinics that remain, while patients who cannot make the long trip or get into an overloaded clinic will lose access to services.[47] Patients in rural areas will suffer disproportionately, as they are more likely to be uninsured and underserved by health care providers generally.[48] Rural clinics are more likely to close entirely absent federal funding, exacerbating public health disparities among already underserved patients.[49] Students, too, will be especially impacted by the loss of Title X clinics near Washington colleges and universities, jeopardizing student health and educational attainment.[50] In the unlikely event that the remaining 11% of the network stays in place with no staff losses,[51] these clinics cannot come close to filling the massive gap left by the departing

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[46] Harris Decl. ¶ 61.

[47] Harris Decl. ¶ 62.

[48] Harris Decl. ¶¶ 65–66; WA cmt. at 23, 25; *see also* AMA cmt. at 4; ACOG cmt. at 11–12; CA cmt. at 13–14.

[49] Harris Decl. ¶ 66; Eastlund Decl. ¶ 11; WA cmt. at 25.

[50] Harris Decl. ¶¶ 67, 91; Eastlund Decl. ¶¶ 6–7; *see* WA cmt. at 3 & n.9; NWLC cmt. at 7 & n.22; PPFA cmt. at 95.

[51] *See supra* n.44.

subrecipients.[52] For instance, Federally Qualified Health Centers (FQHCs) in Washington are structurally and financially unable to handle a massive influx of patients,[53] leaving many without care. HHS offered no evidence to support its "belie[f]" that new clinics able and willing to comply with the Final Rule will somehow rush in to immediately fill the massive gaps in the network.[54]

The Final Rule's drastic and harmful new requirements are not limited to clinics and their patients—they will also impact Washington's ability to continue administering a Title X program at all. For instance, the separation provisions extend so far as to require DOH to *physically* separate its Olympia-based administration of Washington's statewide Title X program from any State

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[52] Harris Decl. ¶ 68. Studies show that when specialized family planning clinics such as Planned Parenthood are excluded from statewide networks, patients lose access to care, and clinics that remain in the network are unable to fill the gaps even when the program is adequately funded. *See* ACOG cmt. at 12-13; APHA cmt. at 4; NFPRHA cmt. at 34; PPFA cmt. at 16, 20; GW Fac. cmt. at 2–3; Beneski Decl. Ex. 5.

[53] Marsalli Decl. ¶¶ 8–11; *see also* ACOG cmt. at 12; Guttmacher cmt. at 14 & Table 2; PPFA cmt. at 16, 78.

[54] Supp. Info., 84 Fed. Reg. 7766.

activities related to abortion.[55] Even if Washington could continue its Title X program despite this crippling burden, that program would receive less federal funding due to network shrinkage as discussed above, and would offer substandard care that would harm patients and increase costs in Washington.[56]

If its Title X funds disappear entirely because of the Final Rule, Washington's program will lose one third of its current funding. DOH would suddenly have far less funding to allocate to family planning providers, resulting in fewer patients receiving services and a more limited scope of services.[57] DOH estimates that up to 72,000 Washingtonians would lose access to subsidized family planning if this occurred.[58] The 16,000 Title X patients in Washington who pay on a sliding scale may no longer be able to afford needed care if they lose access to a Title X clinic and have to pay full price.[59] With fewer patients being able to access the most effective forms of contraception, STI testing, cancer screening, and other reproductive health care, the inevitable consequences will

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[55] Harris Decl. ¶ 82; Maisen Decl. ¶¶ 26–37.

[56] Harris Decl. ¶¶ 70–71, 84; *see infra* at 23–24, 32–34.

[57] Harris Decl. ¶¶ 88–89, 94.

[58] Harris Decl. ¶ 89.

[59] Zerzan-Thul Decl. ¶ 18.

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include more unintended pregnancies,[60] more maternal deaths,[61] adverse maternal and pediatric health outcomes, undetected cancers, and other public health problems.[62] Analyses show that nationally, every $1 spent on family planning services results in over $7 of cost savings[63]—savings that will be slashed when the Final Rule impedes access to these services.

The State of Washington will bear increased public health costs. In 2017, Title X services saved the State multiple millions of dollars that otherwise would have been spent addressing preventable health issues; the costs imposed by the Final Rule will be well over $100 million, and are projected at $28 million in the first year alone if the rule is not enjoined.[64] The State's Health Care Authority,

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[60] *See* WA cmt. at 26; AAN cmt. at 3; ACOG cmt.at 2; ACP cmt. at 4; APHA cmt. at 5; CA cmt. at 4, 14, 16; JIWH cmt. at 1, 4–5; NFPRHA cmt. at 4, 31–35; PPFA cmt. at 18, 80; GW Fac. cmt. at 7.

[61] Maternal mortality has been rising in the United States. CA cmt. at 13 & n.21; Beneski Decl. Ex. 6; Compl. ¶ 78 n.28.

[62] Harris Decl. ¶ 96; WA cmt. at 26; PPFA cmt. at 15–22, 33, 70, 80–81; NFPRHA cmt. at 31–35; CA cmt. at 4, 14; Compl. ¶¶ 159, 167–168.

[63] Beneski Decl. Ex. 7; WA cmt. at 26; ACOG cmt. at 2; Guttmacher cmt. at 19; NFPRHA cmt. at 32; PPFA cmt. at 80.

[64] WA cmt. at 5; Harris Decl. ¶ 95.

which administers its Medicaid program (Apple Health) and other public health programs, currently funds nearly 50% of all births in Washington State, a figure likely to increase if unintended pregnancies rise due to the Final Rule.[65] Apple Health will pay for the care of many women who experience an unintended pregnancy after losing access to Title X services: currently, 81% of Title X clients are eligible for Apple Health or would become eligible in the event of a pregnancy; others may become eligible if a pregnancy affects their income by forcing them to stop working or reduce their hours, or by changing their family size.[66] Patients who are ineligible for Apple Health and who lose access to Title X services would turn to other parts of the safety net, or fall through the cracks.

Washington raised its serious concerns about network destruction in public comments on the proposed rule that preceded the Final Rule,[67] but HHS failed to address or even acknowledge Washington's unique concerns. Indeed, network destruction is part and parcel of the Trump Administration's goal in promulgating the Final Rule, which is to penalize clinics that provide abortion care *independent* of Title X.[68] HHS fundamentally fails to grapple with the real-world

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[65] Zerzan-Thul Decl. ¶ 15.

[66] Zerzan-Thul Decl. ¶¶ 7, 13, 15, 19.

[67] WA cmt. at 24 & Att. 1.

[68] *See* Compl. ¶¶ 135–138.

consequences of the Final Rule's drastic and politically motivated changes.

III. ARGUMENT

A. Legal Standard

"The familiar *Winter* standard provides that 'a plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest.' " *Saravia for A.H. v. Sessions*, 905 F.3d 1137, 1142 (9th Cir. 2018) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008)). Under the Ninth Circuit's "sliding scale" approach, these elements are "balanced, so that a stronger showing of one element may offset a weaker showing of another." *Hernandez v. Sessions*, 872 F.3d 976, 990 (9th Cir. 2017).

B. Washington Is Likely To Succeed on the Merits of Its Administrative Procedure Act Claims

Washington is likely to succeed on the merits of its claims under the Administrative Procedure Act (APA). The Final Rule should be "[held] unlawful and set aside" because it is contrary to multiple controlling statutes, exceeds the agency's rulemaking authority, and is arbitrary and capricious. 5 U.S.C. § 706.

1. The Final Rule is contrary to law

Under the APA, courts must set aside agency action "in excess of statutory jurisdiction, authority, or limitations" or otherwise "not in accordance with law."

5 U.S.C. §§ 706(2)(A), (C). Where, as here, a plaintiff alleges that agency action is contrary to law, courts apply the framework established in *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984). *See Nw. Envtl. Advocates v. E.P.A.*, 537 F.3d 1006, 1014 (9th Cir. 2008). Under *Chevron*, the court "must give effect to the unambiguously expressed intent of Congress." 467 U.S. at 843. If "Congress has directly spoken to the precise question at issue" and "the intent of Congress is clear, that is the end of the matter." *Id.* at 842. "If the statutory language is plain, [the court] must enforce it according to its terms." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015). Even where a statute contains an ambiguity, no deference is owed to a *post hoc* agency interpretation advanced for the first time in litigation, absent a formal rulemaking process. *Price v. Stevedoring Serv. of Am., Inc.*, 697 F.3d 820, 830 (9th Cir. 2012).

The Final Rule violates *multiple* statutes plainly mandating (1) that Title X pregnancy counseling be nondirective; (2) that HHS is forbidden to promulgate any rule that creates barriers or impedes timely access to medical care, interferes with patient–provider communications, or violates medical ethics or principles of informed consent; and (3) that receipt of Title X services and information be strictly "voluntary," among other requirements of Title X's text and purpose.

a. The Final Rule violates the Nondirective Mandate

Every year since 1996, Congress has included the Nondirective Mandate in its appropriations acts. As to the amounts allocated for Fiscal Year 2019 "for

carrying out the program under title X of the PHS Act to provide for voluntary family planning projects, . . . all pregnancy counseling shall be nondirective[.]"[69]

The Final Rule defies Congress's mandate by requiring that *all* pregnant patients receive directive referrals for prenatal care—regardless of whether the patient intends to continue the pregnancy, or whether the medical care provider believes the referral is appropriate in light of the patient's individual needs and choices. Although section 59.14(b) pays lip service to the Nondirective Mandate by purporting to permit "nondirective" counseling if a provider chooses to offer it, the prenatal care referral requirement renders *any* counseling directive and coercive because it pushes patients toward one option (carrying to term) and away from another (abortion). Directing patients to the government's preferred type of medical care in response to a pregnancy cannot be reconciled with the Nondirective Mandate. Even if pregnancy counseling that includes a mandatory prenatal care referral could somehow be genuinely nondirective, the Final Rule makes such counseling optional, as opposed to making it available to all patients as required by the Nondirective Mandate. As alternatives to "nondirective" counseling, the Final Rule lets providers instead choose to give pregnant patients only politically biased "[i]nformation about maintaining the health of the mother

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[69] Pub. L. No. 115-245; Compl. ¶ 49.

and unborn child during pregnancy,"[70] and permits referrals to "social services or adoption agencies" but not to abortion clinics. Final Rule § 59.14(b)(1).

These clear violations of the Nondirective Mandate render the Final Rule invalid. *See E. Bay Sanctuary Covenant v. Trump*, 909 F.3d 1219, 1247 (9th Cir. 2018) ("an agency's authority to promulgate categorical rules is limited by clear congressional intent to the contrary"). HHS lacks the power to adopt regulations that contradict the means (i.e., nondirective counseling) by which Congress directed it to implement Title X. *See Waterkeeper Alliance v. E.P.A.*, 853 F.3d 527, 535 (D.C. Cir. 2017) (agencies and reviewing courts are "bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes") (quoting *MCI Telecomms. Corp. v. AT&T*, 512 U.S. 218, 231 n.4 (1994)). The coercive counseling provisions (§§ 59.5), and the required separation of nondirective counseling from Title X activities (§ 59.15), are unlawful statutory violations.

b. The Final Rule violates section 1554 of the ACA

Section 1554 of the ACA preserves the sanctity and integrity of the patient–provider relationship by prohibiting interference by federal regulators. It bars HHS from adopting "any" regulations, under Title X or otherwise, that

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[70] "Unborn child" is a non-medical term signaling an ideological view of reproductive health care. *See* ACOG cmt. at 4; Guttmacher cmt. at 7.

impede patients' access to medical information and quality care. 42 U.S.C. § 18114. HHS failed to even mention or consider these "clear" and "unambiguous" limitations on its authority, which cannot be reconciled with the Final Rule. *Chevron*, 467 U.S. at 842–43; *E. Bay Sanctuary Covenant*, 909 F.3d at 1247.

The Final Rule "impedes timely access to care" and "creates . . . unreasonable barriers to the ability of individuals to obtain appropriate medical care" (§§ 18114(1), (2)) in a number of ways, including by imposing onerous, unworkable, and unnecessary physical separation requirements and mandating unethical practices that will disqualify and drive out the vast majority of current Title X providers in Washington, thereby reducing patients' access to family planning services—especially in rural areas.[71] Requiring total physical separation of abortion care (and other newly prohibited activities like nondirective pregnancy counseling) is cost-prohibitive for many clinics and burdensome for patients.[72] Those who live in one of the 21 Washington counties that will lack a Title X provider because of the Final Rule will have to travel long distances to reach the nearest clinic, which may be impossible for some. Even for patients who are able to make the trip, the Final Rule impedes timely access by broadly prohibiting them from receiving referrals

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[71] *Supra* at 13–14.

[72] *Supra* at 12, 14; ACP cmt. at 6; CBD cmt. at 2.

for abortion care (subject to an illusory exception that is meaningless in Washington),[73] leaving most patients to attempt to find a provider of the desired care on their own. Timely access is important because, while abortion is always safe (and "markedly safer than childbirth"), it is safest when performed early in a pregnancy.[74] The Final Rule further impedes access by artificially separating the provision of related health services,[75] and needlessly requiring clinics to divert resources from caring for patients to achieve separation.[76]

The Final Rule "violates the principles of informed consent and the ethical standards of health care professionals" (§ 18114(5)) by requiring providers to withhold medically relevant information from their patients, coerce them into treatment that may be unwanted and unneeded, and knowingly depart from medical standards of care and fiduciary obligations to disclose information.[77] It

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[73] There are no known primary care providers in Washington that offer abortion care. Harris Decl. ¶ 54; *see* Final Rule § 59.14(c)(2).

[74] Compl. ¶ 77 & n.26; Dr. Steinauer cmt. at 2 & n.6.

[75] PPFA cmt. at 33–34.

[76] *Supra* at 12; Compl. ¶ 99; PPFA cmt. at 31–34.

[77] HHS ignored numerous comments detailing the ethical standards for health care providers, including the central principle of informed consent. *See, e.g.*, WA cmt. at 11 & nn.41–42; AMA cmt. at 3; ACOG cmt. at 1, 3–6; NFPRHA

also "interferes with communications regarding a full range of treatment options between the patient and the provider" and "restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions" (§§ 18114(3), (4)) by requiring coercive counseling in violation of the Nondirective Mandate as described above.

c. The Final Rule violates Title X's text and purpose

"'In order to be valid regulations must be consistent with the statute under which they are promulgated.' " *E. Bay Sanctuary Covenant*, 909 F.3d at 1248 (brackets omitted) (quoting *United States v. Larionoff*, 413 U.S. 864, 873 (1977)). Regulations "inconsistent with the statutory mandate or that frustrate the policy that Congress sought to implement" are invalid. *F.E.C. v. Democratic Senatorial Campaign Comm.*, 454 U.S. 27, 32 (1981).

Title X's central purpose is to equalize access to comprehensive, evidence-based, voluntary family planning services. The combined effect of the unlawful aspects of the Final Rule—the separation requirements, coercive

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cmt. at 6, 8–11, 21 & nn.43, 87–89; Guttmacher cmt. at 7–8 & nn.15–20; *id.* at 12, 16; PPFA cmt. at 10–15 & nn.38–55; ACP cmt. at 5 & nn.3, 5, 9, 11; ACNM cmt. at 3 & n.6; APHA cmt. at 2–3; CA cmt. at 5–7; JIWH cmt. at 3; Dr. Steinauer cmt.; NIRH cmt. at 3–4; *see* Compl. ¶¶ 81–84. *See also* Prager Decl. ¶¶ 16–25, 32–33, 36, 42, 48; Madden Decl. ¶¶ 20–22, 35; Kruse Decl. ¶¶ 11–19, 30–31, 40.

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counseling provisions, and others—will significantly *reduce* access to these services, frustrating the statute as a whole in service of HHS's broad new interpretation of section 1008. This outcome "allow[s] the exception to swallow the rule, thereby undermining the purpose of the statute itself." *Nat'l Fed'n of Fed. Emps. v. McDonald*, 128 F. Supp. 3d 159, 172 (D.D.C. 2015). These unethical and onerous provisions will drive out the vast majority (if not all) of Washington's existing network of Title X clinics, and it will no longer be feasible for DOH to administer a Title X program while also performing other public health-related duties. As a result, Washington patients in need will lose access to family planning and related preventive health services, and others will receive a diminished level of care inconsistent with medical standards from clinics that may offer a sharply limited range of non-medically approved options.[78]

The Final Rule violates individual statutory requirements as well, including Title X's directive that the acceptance of family planning "services" and "information" "shall be voluntary[.]"[79] The "voluntary" requirement—referenced several times in the statute and in its title—forbids clinicians from providing patients with unwanted information or coercing them into unwanted medical treatment, but the Final Rule requires exactly that. In addition, the Final

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[78] *See infra* at 29–31.

[79] 42 U.S.C. § 300a-5; *see also id.* § 300(a).

Rule inexplicably limits the use of Title X funds for core functions such as "bulk purchasing of contraceptives," "clinical training for staff," and "community outreach," including development and distribution of "educational materials."[80] Title X expressly contemplates that funds should be used to "offer . . . effective family planning methods" and "develop[] and mak[e] available family planning . . . information (including educational materials)."[81]

These numerous statutory violations on their own are more than enough to establish Washington's likelihood of success on the merits at this stage.

2. The Final Rule is arbitrary and capricious

In addition to violating multiple statutes, the Final Rule is arbitrary and capricious. Its harmful new requirements further an improper goal: to shift TitleX away from its original bipartisan vision of equalizing access to modern, effective contraception, and toward policy preferences ungrounded in law or public health. In pursuit of this goal, HHS overhauled decades of Title X regulations while ignoring and brushing aside its own precedent, its evidence-backed Program Requirements, and the extensive public comments opposing the rule. HHS made no serious effort to balance these real-world problems against the speculative and baseless "risks" of improper commingling and public misperception it used to

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[80] Final Rule § 59.18; Supp. Info., 84 Fed. Reg. 7774.

[81] 42 U.S.C. §§ 300(a), 300a-3(a).

justify the sweeping changes. Its rationales for various aspects of the Final Rule are illogical, unsupported, and contrary to the evidence in the "whole" administrative record. *See* 5 U.S.C § 706.

Courts must set aside agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2). To survive judicial review, the agency action must be based on a "reasoned analysis" that indicates the agency "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choice made." *Motor Vehicle Mfrs. Ass'n of U.S. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42–43 (1983) (citation and internal quotation marks omitted). When an agency reverses position, it must "supply a reasoned analysis for the change," *id.* at 42, and may not "depart from a prior policy *sub silentio* or simply disregard rules that are still on the books," *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009). Further, any "serious reliance interests must be taken into account," *id.*, particularly where "decades of . . . reliance on the Department's prior policy" demand a fulsome explanation for the reversal. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016). In general, a rule is arbitrary and capricious where the agency "relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible

that it could not be ascribed to a difference in view or the product of agency expertise." *State Farm*, 463 U.S. at 43. "[A]gency action is lawful only if it rests 'on a consideration of the relevant factors,' " *Michigan v. EPA*, 135 S.Ct. 2699, 2707 (2015) (quoting *State Farm*, 463 U.S. at 43), and the agency must consider "the advantages *and* the disadvantages" of the proposal before taking action, *id.* HHS's Final Rule is arbitrary and capricious for a host of reasons.

a. Failure to consider medical ethics and patient-focused care

HHS failed to justify the Final Rule's interference in the patient–provider relationship, which needlessly endangers patients' health and undermines their trust in the health care system. *Cf. Nat'l Inst. of Family & Life Advocates v. Becerra*, 138 S.Ct. 2361, 2374 (2018) ("[T]his Court has stressed the danger of content-based regulations in the fields of medicine and public health, where information can save lives.") (citation and internal quotation marks omitted). "High-quality health care is founded on complete, accurate, and unbiased information and relies on a relationship of trust between a patient and their health care professional."[82] Impacts on the "ethical standards of health care professionals" and "principles of informed consent" are important factors that Congress directed HHS to consider as part of *any* rulemaking. 42 U.S.C. § 18114(5). Yet the agency completely disregarded extensive and unanimous

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[82] AAN cmt. at 4; *see also supra* n.77.

public comments from leading medical associations, public health policy organizations, medical and infrastructure experts, and states (including Washington) pointing out that the coercive and misleading counseling provisions create serious ethical and legal problems for physicians, nurses, and other clinicians.[83] HHS barely acknowledged these concerns, and failed to respond directly to a single one of the specific ethical problems raised by commenters.[84]

A primary justification for the unethical counseling requirements is that HHS wanted to expand eligibility for Title X funds to "diverse" providers who are no longer obligated to offer "medically approved" contraceptive methods and who object to nondirective counseling, including referral for abortion.[85] This justification is irrationally overbroad,[86] and there is no indication that Congress wanted HHS to prioritize the interests of an unknown minority of health care providers over the needs of the patients whom Title X was intended to help (and

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[83] *See supra* n.77.

[84] *See* Supp. Info., 84 Fed. Reg. 7748 (HHS "does not believe" the Final Rule violates ethical requirements, offering no supporting analysis or evidence).

[85] *Id.* at 7716–17, 7719, 7746–47; *see supra* n.38.

[86] *See* Compl. ¶ 86; *see also, e.g.*, PPFA cmt. at 8 (conscience laws are not "a sword to be wielded against all *other* providers").

the ethical obligations of all medical care providers).[87] Prioritizing "conscience" objectors, while simultaneously excluding experienced clinics with a demonstrated ability to provide a full range of FDA-approved options, undermines Title X's requirement that projects offer a "broad range" of "effective" family planning methods and services.[88] Even if HHS's "conscience" rationale had some legitimacy (which it does not), the agency cannot rely on it exclusively while disregarding several "important aspect[s] of the problem" Congress expressly identified. *State Farm*, 463 U.S. at 42–43, 55.

HHS fails to offer any rational justification whatsoever for the Final Rule's other intrusions into the patient–provider relationship. It fails to explain why "medically indicated" abortion referrals are no longer permitted (*see* § 59.5(b)(1)), or to justify putting patients in danger by withholding referrals and delaying access to care (§§ 59.5(a)(5), .14);[89] fails to explain why the Final Rule does not permit qualified nurses and trained staff to provide "nondirective" pregnancy counseling (although any Title X staff are permitted to provide

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[87] *See* Compl. ¶ 86.

[88] 42 U.S.C. § 300(a).

[89] *Supra* n.29; *see* Compl. ¶¶ 77–80; PPFA cmt. at 92; ACOG cmt. at 5–6; AMA cmt. at 3; CA cmt. at 16; Guttmacher cmt. at 8; Dr. Steinauer cmt. at 2.

directive counseling) (§§ 59.2, .14(b)(1));[90] and tries to rationalize the coercive, directive, and demeaning requirement that all pregnant patients be given prenatal care referrals (§ 59.14(b)(1)) on the irrelevant grounds that prenatal care is deemed "medically necessary" for purposes of Medicaid reimbursement—which has no bearing on whether such care is appropriate for all patients.[91]

b. Disregarding program requirements and standards of care

In its drive to remake the Title X program as a vehicle for the Administration's unrelated policy goals, HHS also ignored its own Program Requirements—including the QFP, which was prepared by HHS's sub-agencies in 2014, backed by extensive research, and fully reaffirmed in December 2017.

The Final Rule contradicts standards of care, including those reflected in the QFP, in a number of ways: by mandating coercive and directive pregnancy counseling (§ 59.5, .14); permitting providers to offer limited, non-medically-approved family planning options (*see* § 59.5(a)(1)); prohibiting referrals for abortion absent a medical "emergency" (§ 59.14(b));[92] and requiring separate sets

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[90] Compl. ¶ 75.

[91] Zerzan-Thul Decl. ¶ 11 (prenatal care is not appropriate if a pregnancy will be terminated); Kimelman Decl. ¶¶ 9–10 (same); *see* 84 Fed. Reg. 7762.

[92] This restriction also exceeds HHS's rulemaking authority to the extent it regulates referrals for abortion that are needed to protect the patient's life,

of medical records for any patients who receive abortion care or counseling (§ 59.15). Contrary to these provisions, the QFP requires "client-centered" care, which for pregnant patients includes nondirective "[o]ptions counseling" with "appropriate referrals," consistent with ACOG standards; if "pregnancy abnormalities or problems are suspected," the QFP requires treatment or appropriate referral, *regardless* of whether there is an "emergency."[93] The QFP emphasizes that clinics should offer a "full range of FDA-approved contraceptive methods,"[94] and stresses the importance of consistent electronic health records to ensure accuracy and improve patients' health.[95]

The Final Rule's heedless departures from these prevailing standards put patients' lives and health at risk. Requiring separate records is not only extremely costly[96]—it increases the likelihood of medical error, posing a "considerable

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health, or safety, including in cases of rape or incest, which are outside Title X's scope. *See* 42 U.S.C. § 300a-6; *see* Compl. ¶ 78 & n.27.

[93] QFP (Beneski Decl. Ex. 3) at 2, 4, 13–14.

[94] *Id.* at 2, 7, 10 (Fig. 3), 11, 24, 39.

[95] *Id.* at 22, 24; *see also* 42 U.S.C. § 300jj-11 (emphasizing importance of integrated electronic health records and establishing federal standards re same).

[96] NFPRHA cmt. at 36–37 (changing *one* electronic template could cost $30,000 per clinic—a fraction of the cost of creating a separate new system).

health risk to patients."[97] Failing to refer patients for needed care and impeding their ability to choose effective, FDA-approved contraceptives predictably harms their health and well-being,[98] and in the long run, will undermine trust in the medical care system, worsening health outcomes overall.[99] HHS fails to "supply a reasoned analysis" for departing from the QFP. *State Farm*, 463 U.S. at 42. Indeed, it fails to even *acknowledge* the QFP, reversing it *sub silentio*. *See Fox Television Stations*, 556 U.S. at 515; *see also Lone Mountain Processing, Inc. v. Sec'y of Labor*, 709 F.3d 1161, 1164 (D.C. Cir. 2013) (agency must show that prior policies are not being "casually ignored"). HHS quietly ignored the QFP for good reason: it cannot rationally justify requirements that fly in the face of evidence-backed medical standards and principles of patient-centered care.

c. Network destruction and unnecessary burdens

The Final Rule's unworkable and unnecessary physical separation requirements, along with its invasion of the patient–provider relationship to mandate unethical medical care, will force out the subrecipients and clinics

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[97] PPFA cmt. at 34 & n.135; WA cmt. at 24; Compl. ¶ 104.

[98] *Supra* at 16–17.

[99] *See* AMA cmt. at 2; ACOG cmt. at 3; PPFA cmt. at 11 & n.42; NFPRHA cmt. at 4, 10, 21–24; ACNM cmt. at 3.

comprising the vast majority of Washington's Title X network.[100] Any remaining clinics will be excessively burdened by the *ultra vires* "comprehensive primary health care" requirement (§ 59.5(a)(12));[101] the new limitations on the use of grant funds (§ 59.18);[102] and the vagueness of the separation "factors," which increase uncertainty and the cost of compliance—particularly since the Final Rule establishes an initial grant eligibility hurdle (§ 59.7(b)) that gives HHS considerable discretion to arbitrarily reject applications prior to merits review.[103]

Washington explained in its public comments that these burdensome requirements will leave over half its counties without a Title X provider, with the devastating effects falling "particularly hard on uninsured patients and those in rural areas, who in some cases will have no other reasonable option for obtaining

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[100] *Supra* at 13–14, 23–24.

[101] Requiring family planning clinics to provide primary care or be in "close proximity" to a referral source is costly and will disqualify clinics located in already-underserved areas. Compl. ¶¶ 119–120; WA cmt. at 20; AMA cmt. at 4; ACOG cmt. at 13; ACP cmt. at 8–9; PPFA cmt. at 70. Moreover, it exceeds HHS's rulemaking authority, since Title X pertains exclusively to "family planning" services, not primary care. *See generally* 42 U.S.C. § 300 *et seq.*

[102] *See supra* at 26–27 & n.80.

[103] Compl. ¶¶ 126–129; NFPRHA cmt. at 14; PPFA cmt. at 31.

family planning services."[104] Lack of access to Title X services will worsen public health outcomes—and increase costs to the State—because the number of unintended pregnancies will rise, more STIs and cancers will go undetected and untreated, and more people will become eligible for (and in need of) safety-net care.[105] Title X preventive care saves millions of dollars a year in health care costs.[106] Yet in promulgating the Final Rule, HHS turned a deaf ear to the concerns of Washington and other grantees; the agency simply asserted, with no evidence, that it "does not believe" the Final Rule will have *any* impact on patients' access to care.[107] In baselessly claiming that patients will be unaffected,

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[104] WA cmt. at 23–26 & Att. 1; *see also* Guttmacher cmt. at 9 (separation requirements will "effectively exclude" clinics that offer abortion or are affiliated with clinics that do so); Compl. ¶¶ 87–89, 93, 99, 139–153.

[105] *See* WA cmt. at 23–27 (rule will "reduce access to essential preventive health services" and "impose tens of millions of dollars of costs" on state treasuries); NFPRHA cmt. at 31–35 (lack of access due to Final Rule is "likely to lead to a significant public health crisis"); PPFA cmt. at 15–22 (extensively discussing "gaps in access to care, harm [to] population health," and "significant, unnecessary costs" the rule will cause); *see supra* at 16–18.

[106] Beneski Decl. Ex. 7.

[107] Supp. Info., 84 Fed. Reg. 7725; *see also id.* at 7766, 7775, 7785.

HHS also implied that complete physical separation would somehow be simple and cheap: it wildly underestimated the costs and burdens without backing up its lowball "estimate"[108] or justifying its rejection of substantiated cost assessments submitted in public comments.[109]

The Final Rule's destruction of existing, effective family planning networks, and the resulting loss of access to much-needed care, is another "important aspect of the problem" that HHS failed to confront or address. Title X's concerns with serving high numbers of patients and adequately addressing local needs, *see* 42 U.S.C. § 300(b), and its stated purpose of making "comprehensive" services "readily available to all," Pub. L. No. 91-572, § 2,

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[108] *See id.* at 7718, 7782 (estimating costs at $30,000 per clinic and $36 million nationwide, citing no evidence); *id.* at 7781 (asserting that moving abortion care and referral to "distinct facilities" "likely entails only minor costs").

[109] *See* PPFA cmt. at 31–33 (cost estimates of $.5 to $1.5 million; duplicating operations would further increase costs by 50–100%); Prof. Brown cmt. (HHS's cost estimate is "completely unrealistic"); NFPRHA cmt. at 36–37 (costs will be "orders of magnitude more" than HHS's estimate); MO FHC cmt. at 8 (locating and opening health facilities "costs hundreds of thousands, or even millions, of dollars"); WA cmt. at 23; ACP cmt. at 6; APHA cmt. at 6; CBD cmt. at 2; Compl. ¶¶ 87–89 & n.32, 97–100; *see also* Eastlund Decl. ¶¶ 14–20.

show that network adequacy and access to care are critical, central issues. Congress also expressly identified "timely access" and "barriers" to medical care as issues HHS must account for as part of *any* rulemaking. 42 U.S.C. §§ 18114(1), (2). HHS offered no evidence that its concerns about "potential" commingling or a "risk" of confusion are anything more than speculative[110] and failed to respond to comments regarding the adequate and "thorough" monitoring and compliance systems already in place.[111] Even assuming HHS's unfounded concerns have *some* relevance, the agency cannot rely on them exclusively while completely ignoring factors that Congress actually deemed important.

d. Failing to consider reliance interests

The Final Rule ignores and undermines reliance interests developed during five decades of Title X regulation. *See Fox Television Stations*, 556 U.S. at 515 (2009). Washington has for decades relied on being able to administer its family planning program without having to physically separate its work on other State

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[110] In fact, HHS admits that "demonstrated abuses of Medicaid funds do not necessarily mean that Title X grants are being abused . . ." Supp. Info., 84 Fed. Reg. 7725. And HHS fails to explain why these "risks" justify physical separation of abortion care, but not other out-of-program care that a Title X clinic may provide (such as prenatal care). *See* Compl. ¶ 102.

[111] WA cmt. at 16–18; CA cmt. at 19–20; *see* Harris Decl. ¶¶ 41–49.

business.[112] Providers and clinics rely on being able to provide Title X services without violating their professional responsibilities, and patients expect providers to act ethically and fulfill their fiduciary duties regardless of who funds their services.[113] Patients also rely on being able to obtain comprehensive reproductive health services from specialized clinics,[114] whether federally funded or not—but an abrupt loss of funding will force at least some current Title X clinics to close or reduce their services, leaving vulnerable patients without access to what may be their only source of care.[115] Simply brushing aside these "decades of . . . reliance on the Department's prior policy" without adequate justification, as HHS has done, is unacceptable under the APA. *Encino Motorcars*, 136 S. Ct. at 2126.

C. Washington Will Suffer Irreparable Harm Absent Preliminary Relief

The harm analysis "focuses on irreparability, irrespective of the magnitude of the injury." *California v. Azar*, 911 F.3d 558, 581 (9th Cir. 2018) (internal quotation marks omitted). Washington is irreparably harmed in at least three

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[112] Harris Decl. ¶ 11; *see* Compl. ¶¶ 107, 141; *supra* at 15–16.

[113] Maisen Decl. ¶¶ 20, 40–42; Kruse Decl, ¶¶ 2, 17–32, 38–39; Eastlund Decl. ¶ 8; *see* Compl. ¶¶ 81, 141.

[114] Compl. ¶ 56 & n.22.

[115] *Supra* at 13–15.

ways. The Final Rule is likely to (1) seriously disrupt or destroy Washington's existing Title X network, (2) impose uncompensable financial costs on the State, and (3) harm the health and well-being of Washington patients and providers.[116]

First, Washington will be harmed because the Final Rule will destroy its family planning network, forcing out subrecipients and clinics that served almost 90% of Title X patients in 2017.[117] Federal action that undermines a state program and impedes its purpose constitutes irreparable harm. "An organization is harmed if the actions taken by [the defendant] have 'perceptibly impaired' the [organization's] programs." *League of Women Voters of U.S. v. Newby*, 838 F.3d 1, 8 (D.C. Cir. 2016) (internal quotation marks and citation omitted); *see also Fair Emp't Council of Greater Wash., Inc. v. BMC Mktg. Corp.*, 28 F.3d 1268, 1276 (D.C. Cir. 1994) (anti-discrimination organization was injured because defendant's "discriminatory actions . . . interfered with [plaintiff's] efforts and programs and . . . also required [it] to expend resources to counteract" the discrimination); *Valle del Sol Inc. v. Whiting*, 732 F.3d 1006, 1029 (9th Cir. 2013) ("ongoing harms to [plaintiffs'] organizational missions" established likelihood of irreparable harm); *E. Bay Sanctuary Covenant v. Trump*, 354 F. Supp. 3d 1094,

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[116] "That [Washington] promptly filed an action following the issuance of the [Final Rule] also weighs in [its] favor" for the irreparable harm analysis. *Id.*

[117] *Supra* at 13–16.

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1116 (N.D. Cal. 2018) ("the Organizations 'have established a likelihood of irreparable harm' based on their showing of serious 'ongoing harms to their organizational missions,' including diversion of resources and the non-speculative loss of substantial funding from other sources") (quoting *Whiting*, 732 F.3d at 1029).[118] Based on the extensive evidence of network destruction discussed above, Washington satisfies this standard. Given the imminent loss of almost 90% of Washington's Title X network because of the Final Rule, "the only serious disagreement is not whether [Washington] will be harmed, but *how much*." *Pennsylvania v. Trump*, 351 F. Supp. 3d 791, 828 (E.D. Pa. 2019).

Second, the Final Rule will harm Washington economically, and there is no mechanism by which Washington could recover damages from the United

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[118] Courts routinely find a likelihood of irreparable harm in similar scenarios involving likely clinic closures, staff layoffs, and loss of access to health care services. *See, e.g.*, *Planned Parenthood of Ind., Inc. v. Comm'r of Ind. State Dep't Health*, 699 F.3d 962, 980–81 (7th Cir. 2012); *W. Ala. Women's Ctr. v. Williamson*, 120 F. Supp. 3d 1296, 1317–20 (M.D. Ala. 2015); *Jackson Women's Health Org. v. Currier*, 940 F. Supp. 2d 416, 423–24 (S.D. Miss. 2013); *N.Y. State Nat'l Org. for Women v. Terry*, 886 F.2d 1339, 1362 (2d Cir. 1989) ("Those women denied access cannot be compensated by money damages; injunctive relief alone can assure them the clinics' availability.").

States. Uncompensable economic harm, such as that caused by unlawful federal agency action, satisfies the irreparable harm standard. *Azar*, 911 F.3d at 581.[119] The first component of Washington's economic harm is the loss of granted Title X funds—up to $4 million—that would follow the dramatic contraction of its network.[120] The second component is increased costs to the State of providing family planning services to patients who lose access to Title X clinics, since the income eligibility criteria for state-funded family planning services overlap with the Title X criteria.[121] *See Azar*, 911 F.3d at 572 (economic injury to states was "reasonably probable" where agency rule would increase reliance on state-funded programs). The third component is increased costs to Apple Health and other state programs due to a rise in unintended pregnancies and other health consequences caused by the Final Rule. *See Pennsylvania*, 351 F. Supp. 3d at 827 (finding irreparable harm where states would "become obligated to shoulder

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[119] *See also Idaho v. Coeur d'Alene Tribe*, 794 F.3d 1039, 1046 (9th Cir. 2015); *Texas v. United States*, 809 F.3d 134, 186 (5th Cir. 2015); *Pennsylvania*, 351 F. Supp. 3d at 828; *California v. Health & Human Servs.*, 351 F. Supp. 3d 1267, 1297 (N.D. Cal. 2019).

[120] *Supra* at 16; Harris Decl. ¶ 70 (if it lost most of its network, DOH "would not continue to receive the roughly $4 million current award from HHS").

[121] Harris Decl. ¶ 12; Zerzan-Thul Decl. ¶¶ 7, 10, 19.

much of the burden of providing contraceptive services to women who lose contraceptive care" as a result of agency rules). Here, "[a]s a direct result of HHS's new rule, millions of unnecessary dollars will be spent in Washington to pay for unintended pregnancies, unplanned births, abortions, treatment of sexually transmitted infections, cervical and breast cancer treatment, and other public health risks that the Title X program is designed to prevent."[122]

Third, thousands of Washington residents will be seriously harmed by the Final Rule. Injury to residents' health and well-being irreparably harms the State itself. *See Pennsylvania*, 351 F. Supp. 3d at 828 ("the States also stand to suffer injury to their interest in protecting the safety and well-being of their citizens"); *California v. Health & Human Servs.*, 281 F. Supp. 3d 806, 830 (N.D. Cal. 2017), *aff'd in pertinent part sub nom. California v. Azar*, 911 F.3d 558 (9th Cir. 2018) (finding irreparable injury based in part on "what is at stake: the health of Plaintiffs' citizens and Plaintiffs' fiscal interests"). The Final Rule will harm Washington residents' health by reducing both access to services and quality of services. Some current Title X patients will lose access to family planning services entirely,[123] especially in rural areas, putting their lives and health at

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[122] Zerzan-Thul Decl. ¶ 22; *see also id*. ¶¶ 13, 15, 19; *supra* nn.60–62.

[123] Harris Decl. ¶¶ 59 ("thousands of people in Washington" will lose access), 62, 65–67, 83, 86, 88–89 ("reduction is guaranteed"), 90 (quantifying

risk.[124] Patients who can still access Title X services will be harmed because the Final Rule's unethical and misleading counseling requirements, combined with total physical separation from counseling and care to which patients cannot be referred, will impede patients' ability to obtain the care they want and need and coerce them into receiving unwanted or medically inappropriate treatment.

D. Equity and the Public Interest Strongly Favor an Injunction

When the government is a party, the final two *Winter* factors merge. *Drakes Bay Oyster Co. v. Jewell*, 747 F.3d 1073, 1092 (9th Cir. 2014). The balance of the equities and public interest strongly favor an injunction. "[T]he purpose of such interim equitable relief is not to conclusively determine the rights of the parties, but to balance the equities as the litigation moves forward." *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). "There is generally no public interest in the perpetuation of unlawful agency action. To the contrary, there is a substantial public interest in having governmental agencies abide by the federal laws that govern their existence and operations." *League of*

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residents who would lose services), 91–94; Zerzan-Thul Decl. ¶¶ 10, 21.

[124] Harris Decl. ¶ 97 ("As a result of the Final Rule, more unplanned pregnancies and unwanted childbearing will occur, cervical cancers will not be diagnosed in early stages when they are treatable, and poor health outcomes will result from undiagnosed and untreated STIs"); Zerzan-Thul Decl. ¶¶ 12–13.

Women Voters of U.S. v. Newby, 838 F.3d 1, 12 (D.C. Cir. 2016) (citations and internal quotation marks omitted). As discussed above, the Final Rule is unlawful for numerous reasons and will wreak havoc on a successful and beneficial program. Preserving the status quo will not harm Defendants, and refraining from enforcing the Final Rule will cost them nothing. *See Diaz v. Brewer*, 656 F.3d 1008, 1015 (9th Cir. 2011) (court may waive Rule 65(c) bond requirement).

E. Relief Requested

For all the reasons above, the State of Washington requests that the Final Rule be preliminarily enjoined in full. *See, e.g.*, *Regents of the Univ. of Cal. v. U.S. Dep't of Homeland Sec.*, 908 F.3d 476, 511–12 (9th Cir. 2018); *City of Los Angeles v. Sessions*, 293 F. Supp. 3d 1087, 1100–01 (C.D. Cal. 2018) (enjoining rule nationwide to ensure "even playing field" in competition for federal grants). Alternatively, and pursuant to the same standard, the State requests that the Court stay the rule's effective date during the pendency of this litigation pursuant to 5 U.S.C. § 705. *Cf. Bauer v. DeVos*, 325 F. Supp. 3d 74, 104–05 (D.D.C. 2018). The State requests a ruling prior to the effective date of 12:00 a.m. on May 3, 2019.

IV. CONCLUSION

For all the reasons above, the State of Washington requests that the Court preliminarily enjoin Defendants from implementing or enforcing the Final Rule.

DATED this 22nd day of March, 2019.

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DECLARATION OF SERVICE

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court's CM/ECF System which will serve a copy of this document upon all counsel of record.

DATED this 22nd day of March, 2019, at Seattle, Washington.

/s/ Jeffrey T. Sprung
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Assistant Attorney General